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Text prepared as part of special edition edited by S van der Geest and UM Read *Intimacy, morality and precarity: Transformations in family care in Africa - insights from Ghana*

Title: 'It is left to me and my God': Precarity, responsibility and social change in family care for people with mental illness in Ghana

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Abstract

It has been argued that family care contributes to better outcomes for severe mental illness in Africa and family care is championed as an alternative to institutional treatment. However poor households are experiencing increasing precarity under global economic changes which can be exacerbated by chronic illness. This paper draws on an ethnographic study in Ghana to explore how families negotiate the tension between the moral imperative to provide care and the challenges of daily life with severe mental illness. Changes in family life, household costs and migration can threaten the ability to meet the needs of a severely ill relative and fulfil social ideals of solidarity and responsibility. Such challenges raise questions for the viability of community-based models of mental health care in low-resource settings.

Mental illness and family care in Africa

The role of the family in the care of people with mental illness has long been central to discussions regarding mental health care in sub-Saharan Africa. Early colonial observers viewed the 'traditional' extended family as a valuable resource, a viable alternative to institutionalised care in Europe (Cunyngham-Brown 1937). Colonial anthropologists and medical officers frequently remarked on the 'tolerance' of family care, despite the widespread use of mechanical restraint. Geoffrey Tooth, a colonial medical officer assigned to conduct a survey of mental illness in the Gold Coast, reported: 'There appears to be little social stigma attached to madness, lunatics are well treated in their homes and even when shackled to a log in the traditional manner, the madman is seldom alone for long, is well fed and enjoys the company of his children and friends' (1950:30). Margaret Field, an anthropologist and psychiatrist, conducted a comprehensive study of over 1000 people at shrines in rural Ashanti. After diagnosing those she believed had mental illness she followed many of them up at home. She reported that: 'The majority of chronic schizophrenics in rural districts are treated with [...] patient and sustained kindness by their relatives and tolerance by their neighbours' (1960:453).

Such tolerance and care was assumed to be an important influence on recovery. The anthropologist Meyer Fortes and his wife, Doris Mayer, a psychiatrist, conducted a study of psychosis in Northern Ghana in the 1960s. They conjectured that 'Schizophrenia, at least when treated in the family setting and with the very real support of the whole family, seems to be a more reversible process than it is in more complex societies' (1966:40). The WHO-sponsored global epidemiology of schizophrenia, which began shortly after the publication of their paper, appeared to support this argument, suggesting there was a better outcome for schizophrenia in 'developing countries' (Jablensky et al. 1992). Among the hypotheses to

explain this finding was the role of the family in care. Two of the WHO researchers, for example, claimed that in non-industrial cultures 'expectations and obligations of social help and support are common and accepted over the whole extended family' (Cooper and Sartorius 1977:53).

At the time of Tooth's report, the sun was setting on Britain's colonial expansion and there were financial as well as ideological misgivings about establishing asylums across Africa[1]. The asylums of Victorian England were already falling into disrepute though it would be some decades before there was a commitment to substituting new models of 'community care'. Family care was therefore a pleasing alternative to institutional expansion. In any case, in the early 1950s biomedical treatment of mental illness had little to offer beyond confinement and restraint and the experimental use of insulin and electric shock (Shorter 1997). After independence, the 'traditional' African family informed attempts to develop an 'African psychiatry', in which families rather than government institutions would be central to mental health care. The most celebrated example was Lambo's village psychiatry in Nigeria, in which patients stayed in family homes while receiving hospital treatment (Asuni 1979).

The role of the family remains central to debates concerning the best ways to deliver mental health care in Africa. Community-based care is promoted as optimal for the modern and humane treatment of mental illness, with the person remaining in the family home wherever possible (Thornicroft, Deb, and Henderson 2016). Compared to 'the West', family ties are presumed to be closer and social support more widely available (Alem, Jacobsson, and Hanlon 2008). The objectives of the current WHO Action Plan for Mental Health include

enabling people with mental illness to continue living with the family, and advocate the 'empowerment and involvement' of families in mental health care (WHO 2013).

However the impact of mental illness on family life in settings such as Ghana remains poorly explored. Much of the literature regarding the future of mental care in Africa retains a rather idealised view of the family and communities even as fears are expressed regarding the impact of globalisation, migration and urbanisation on mental health. In settings such as Africa an increase in mental illness has long been considered an inevitable consequence of modernization, including the dissipation of the traditional extended family as a secure haven from the stresses of life (Lucas and Barrett 1995). Cohen traces the trope of 'the decline of the joint family' in the discourse of Indian gerontology hastened by the 'four horsemen of the apocalypse' - modernity, Westernization, industrialisation and urbanization (1998:17). Coupled with this is the rise of 'the Bad Family' who neglect their elders, and in turn bring about an increase in madness in old age. This same trope is repeated in Ghana – the 'bad family' neglects to care for the mentally ill, 'dumping' them at the asylum. This discourse of 'abandonment', also described in India (Pinto 2009), involves an intersection of 'culture' (stigma and exclusion) with practices of confinement instituted by colonial administrations. At the same time mental health professionals in Ghana describe other manifestations of the 'bad family' who subject their members to maltreatment at the hands of traditional healers and Pentecostal pastors and neglect to bring them for psychiatric treatment. Thus the asylum is at once the site of the morally and scientifically proper course of treatment, and a government-sponsored institution of discipline and confinement (Whyte 2012) whose existence stands as evidence of the limits of family care.

Pinto provides a useful critique of an over-determined view of 'the family' in mental health care, arguing instead for an attention to specific relationships, their conflicts and fluctuations (2009:9). It is family life as lived within interpersonal interactions and relationships, rather than enumerated networks of household composition, that determine how family care will be enacted in practice. With the diversity of what constitutes 'family' in Ghana, people participate in 'a complex articulation of systems of access to resources based on lineage, marriage, co-residence and gender which are subject to constant manipulation and negotiation by everyone involved' (Clark 1994:333). Knowing whom the person lives with or who is the 'carer', as in much survey-based research, tells us little about how care is lived out in daily life and over time. Indeed who lives with whom tells us less about the household in Ghana, than who eats from the same pot (Hanson 2004). Kinship, Pinto reminds us, is an inherently 'precarious social process' (2011:393). Conflicts and disputes as much as affections and conviviality are the essence of family life, as reflected in the common African imaginary of witchcraft as the 'dark side of kinship' (Geschiere 1997:42). Such precarity emerges not only as a property of intimate domestic relations but from the interweaving of family life with economic and political changes occurring at the global and national level. Over time such changes have far-reaching consequences for household structure, the meaning of relationships and access to resources, as Han (Han) illustrates in the context of neoliberal reform in Chile. Thus while mental illness may represent a particular crisis for family relationships and the fulfilment of social roles, it occurs within the context of more generalised experiences of household disruption.

It is within this precarious social environment, marked in the Ghanaian context by chronic household poverty, underfunded healthcare systems, and fragile economies, that family care and mental illness is lived out, resulting in what Pinto calls 'the uneven contingencies of care' (2011:383). Whilst Field declared that Ghanaian society had enough solidarity to 'carry

passengers' (1960), for poor households such 'social capital' may only go so far. 'Dumping' at the asylum where treatment, board and lodging is usually provided free[2], may be an attractive option when the person is unable to contribute to household income. The impact of global economic changes in Ghana as elsewhere have been profound. Despite economic growth and transition to middle-income status in 2011, Ghana's economy has suffered steep reversals in recent years. The depreciation of the national currency and high inflation have created a sharp increase in the cost of living. Most of the population remain in 'vulnerable employment' i.e. low-productivity self-employment with low and fluctuating earnings (Honorati and Johansson de Sliva 2016). Structural adjustment in the 1980-90s, and more recent concessions to IMF demands for curtailment of public sector expenditure in return for loans, have further weakened health infrastructure. The mental health budget, already only a small proportion of the total health budget, is largely swallowed up by the country's three psychiatric hospitals (Roberts, Mogan, and Asare 2014). Over the last decade Ghana has received support from WHO and diaspora groups to increase the training of psychiatric nurses and establish new cadres of community mental health workers however there is no ring-fenced budget for them to carry out their mandate. The National Health Insurance Scheme introduced in 2003 does not cover psychotropic drugs, since these are supposed to be provided free of charge through mental health services (hospitals and community psychiatric nurses). However stock-outs of drugs and other essentials are commonplace leading to increased health costs for families who must make out-of-pocket payments for treatment. Coupled with a strong association of mental illness with spiritual powers, and an ever-increasing number of healing churches, it is unsurprising that families continue to patronise traditional and faith healers either as an alternative or adjunct to hospital treatment (Read 2016).

Methods

The findings reported in this paper are derived from an ethnographic study of people living with mental illness in the market town of Kintampo, Ghana, and surrounding rural communities. Fieldwork was conducted between 2006-8 and 2015-16. Initial research involved repeated visits to over forty people with mental illness and their families within household compounds, healing churches (otherwise known as 'prayer camps'), and a shrine.[3]. Twenty-eight of these were followed up in 2015-16. In addition the researchers visited psychiatric treatment facilities and accompanied mental health workers on community visits. Observations and informal conversations were recorded in detailed fieldnotes. Semi-structured individual and group interviews were conducted with people with mental illness, family members, healers and health workers (see Table 1)[4].

The focus of the study was on those with longstanding mental illness resulting in severe disruption of social functioning, closest to what in psychiatric terms would be labelled psychosis or schizophrenia, and in Twi was referred to as '*dam*' (madness). Frequently described behaviours included talking nonsensically, acting aggressively, roaming around, and dressing in dirty clothing, often described using the polyvalent adjective '*basabasa'* – chaotic, unruly, without purpose or meaning. The illness was often characterised by periods of alternating calm and crisis but at the start of the study the majority had been ill for periods of at least five years, some for much longer, leading in many cases to chronic disruption of functioning.

To understand the day-to-day exigencies of care within the family we explored the impact of mental illness on the rituals of daily life: washing, dressing, cooking and eating, making a living, and social interactions. Such mundane 'activities of daily living' (Law, Baum, and

Dunn 2000), can be catastrophically disrupted by mental illness, but have received relatively little attention compared to the exoticism of explanatory models and esoteric modes of healing. Yet it was evident that it was around the cooking fires and in the vegetable gardens of domestic households where the impact of mental illness was most keenly felt. Through such close exploration of daily life, we aimed to glimpse into what it is like to live with serious mental illness in settings with few institutional services and where the support of the 'extended family' could be severely tested. Through this lens we are able to examine the extent to which the ideals and sociomoral values which are presumed to undergird the provision of family care in Africa, such as reciprocity, communitarianism and social responsibility, are lived out in contexts of poverty and social change.

"I have no one except God"

On one of our regular visits to the shrine in 2008 we met Moses[5] and his mother. He was dressed only in a ragged pair of shorts, and, like many of the patients, shackled by the ankles to a post. Moses spoke good English and complained bitterly about his harsh treatment where he was often beaten and forced to drink herbal medicine. He told us he had been brought to the shrine because he had stripped naked in the compound of his house and stood staring at the sun. Moses frankly admitted to smoking '*wee*' (cannabis) which he said helped him to work and stopped him from thinking too much about his problems such as lack of money. He claimed there was nothing wrong with him and expressed hostility towards his mother who had brought him to the shrine.

Moses was 34 years old and the firstborn of his mother's four children. He had completed secondary school. According to his mother he had been very clever at school and she had had hoped that like many of his contemporaries he would travel abroad to work. However in his

mother's words, since he left school 'his life had never been good'. He began training as a motor mechanic but did not complete the course. He had been unable to settle to any work and wandered around, dirty, dishevelled and disturbing the neighbours. Her disappointment was palpable: 'When someone gives birth, they enjoy. As for him, only problems.' She blamed him for using *aduro* ('medicine' i.e. sorcery) which she believed had brought about his illness. His lack of productivity and dirty appearance clearly caused her great social embarrassment in the town, which had on at least one occasion led her to disown him:

> Even me, when he is my own son, when I am speaking to him I feel ashamed because of how he behaves. I feel very ashamed. So one day xx asked me if he is my son. I was standing there and he said I should speak. He said they have heard that he is my son. I told him that he is not my son, he is my elder sister's son. A lot of people know that he is my son. Even me who gave birth to him I feel shy before him because of how he behaves himself.

Moses' mother and father had separated some years ago and Moses' father had taken a new wife with whom he had another family. Moses had two children, a boy and a girl, however the mothers had died in childbirth and they were now being cared for by his mother. Moses' mother had established a business selling cosmetics in town, but the onset of Moses illness had meant she had had to abandon her work in order to care for him at the shrine: 'When we got here they said if I don't have anybody to take care of him, I couldn't go.' By the time of our interview she had been at the shrine for two months.

Moses' siblings supported their mother whilst she was at the shrine, including his brother who worked in a bank, a prestigious job in Ghana. However she felt that since her other son was preoccupied with his work, and she had little help from their father, the main burden of

care was shouldered by her: 'Who else will do it? His father came here only once, he didn't come again. The whole problem is carried by me.' As she put it: 'I have no man except God'. She complained that Moses' father had contributed only a small sum to meet the substantial fees demanded by the shrine. Instead a former classmate of Moses had paid the equivalent of about US$150 to purchase the animals and other items needed to make a divination and commence treatment. More animals and cash offerings worth US$300 remained to be paid to the *ɔkɔmfo* as thanks (*aseda)* before Moses would be permitted to leave[6]. When we interviewed Moses' mother she complained at the loss of her hard-earned savings in meeting the costs of his treatment and the worry and anxiety which had impacted on her health, causing weight loss, body pains and sleeplessness:

> He has worried me oh! This child has worried me very much. He has worried me and worried my children too. Now all the debt … any time I don't have my freedom. This child won't let me have my freedom. I sold pomade little by little and got money that I can use to do something, and I went and took this child - two months […] I was not like this oh! I am a fat person.

As she spoke Moses' mother began to weep and through her tears uttered a tragic and shocking confession: 'So in fact at times I tell God that if he dies, I would like it. He has worried me. If he died, I would be free.'

However it was clear that despite her anguish and frustration and shame at her son's perceived social and moral failings she felt unwilling to abandon him to his fate. Unable to depend on her son's father or siblings, as long as he was living responsibility for his care fell ultimately to her:

> The children say I should ignore him. Can you ignore him? I can't ignore him. If you worry me and I die, none of your siblings will say you [Moses] are mad so he will look after you. Is he not alive?

By 2015 Moses' mother had passed away. Moses remained living in the family house, but was not receiving treatment from mental health services or anyone else. Despite repeated attempts we were not able to meet him but were told he remained unwell, was not working, and continued to smoke cannabis.

Mothering madness

Moving from family homes, to the shrine and prayer camps, it was all too evident that rather than 'the family' what we encountered most was 'the mother'. For most of the people we met with mental illness, as with Moses, day-to-day care fell to the mother, whether at home or in places of treatment. A family member was obliged to stay with a relative who was receiving treatment in order to care for his or her personal and domestic needs – toileting, bathing, fetching water, washing clothes and cooking, as well as helping to administer the prepared herbal mixtures, or, at the prayer camps, participating in healing services and prayers. Mothers were most commonly those who undertook this role, not only due to the gendered division of labour in which women are responsible for childcare and the domestic space, but also due to the greater flexibility allowed by the informal economy in which women were mostly employed. However stays at prayer camps and shrines could be lengthy, often for several months or even longer, and sometimes at some distance from home. For many, like Moses' mother, such care meant the loss of trading, farming and other enterprises, and thus

of independent income, increasing her reliance on the extended family and other networks for support.

The impact of chronic and severe mental illness such as that afflicting Moses could be devastating. Most informants with mental illness were in their twenties and thirties yet far behind their peers. Like Moses, none of those interviewed with long-standing mental illness was able to earn a consistent livelihood, and many were not working at all. Aside from the direct impact of symptoms such as behavioural disturbance, disordered speech, sleeplessness and wandering, mental illness was experienced as 'weakening', removing the bodily strength and motivation needed for physical labour, particularly farm work which was the primary source of informal employment in the rural environs of Kintampo. In addition, only 10 of the 42 case studies had ever married and only three remained so. The consequence was that the person remained in or returned to the family home. Although 13 of the case studies had children, often, as with Moses, they were unable to care for them, and certainly unable to provide for them financially, which could place an additional burden on the grandmother to care for her grandchildren as well as her child. Even in the domestic space, many informants with mental illness did not participate in household chores such as fetching water, washing clothes, and preparing food. Some needed coaxing and chiding to take a bath and change into clean clothes, and help to manage intimate tasks during menstruation or using the toilet. There were also difficult challenges in managing agitation and aggressive or bizarre behaviour.

Moses' mother's comment, 'When someone gives birth, they enjoy', reveals the expectations of children as a social good who, as they move into adulthood and their parents into old age, will take on responsibility for their parents' wellbeing. The impact of mental illness in which

the adult could return to childlike dependency for everyday tasks meant a reversal of these roles, extending the maternal role well past its expected lifespan, and creating even more dependency on the financial support of male relatives. Given this loss of productivity, parents often referred to a mentally ill child as *sɛɛ* 'spoiled', meaning wasted, rotten, destroyed, gone bad. This was accentuated when, like Moses, a child was felt to show particular promise as a 'clever' child at school. Sending a child to secondary school is a crucial first step to meeting ambitions for social mobility within families. Yet since this incurs significant cost it remains within the reach of only a small portion of Kintampo society and can involve considerable family sacrifice. Such expenditure and the student's effort could be considered "wasted" if the child became unwell. We met Samuel, a formerly promising young man from a farming family of modest means, in the prayer camp where he had been treated. He had been unable to finish secondary school and was all too aware that he had exhausted his family's investment in his future:

> I lost my schooling, the work which I would have studied, I don't have any work again. So now even the way I will take to feed myself is a problem. If it had not been for the Prophet or someone will meet me by God's grace and give me some money to go and buy something to eat, it means I won't get help from anywhere since my relatives have wasted their work and wasted their money on me, so now they have to give up.

For women, particularly those who were older and living apart from other children, the loss was not only financial, but also the loss of her child's affection and company. Like Moses, since completing school Yakub had experienced repeated episodes of mental breakdown over several years, disappointing his elderly mother's expectations and hopes. She was divorced

but had worked hard as a trader of farm crops, earning enough to send Yakub to school. She then used her connections to find him a job as a mechanic. Yet despite her sacrifices her son's illness meant she faced old age alone. From a patrilineal family[7] her married daughters had moved to their in-laws, and her oldest son had died. Her experience shares much with that of Moses' mother:

> But me, a woman who has struggled to take care of children, taken them to school, and found them work. Don't they say I have done well? And when it is time for the child to say: "Mother take this," God has suddenly taken him with an illness. And you are alone . . . is it not sad? If it were money, I wouldn't be sad. As for money, God gives. But human sadness has touched me. [….] I am in great sorrow.

'It is left to me and my God': the shrinkage of family care?

In a study of disability and chronic illness in Botswana, Julie Livingston (2005) argues that social, political, and economic changes have challenged ideals of family care-giving, resulting in a "shrinkage" of the family willing or available to provide care. In Ghana the influence of Christianity, urban and international migration, and changing patterns of employment have undoubtedly influenced the structure of the extended family, with many family members living away from their natal village or town and in nuclear family units (Nukunya 2003). Eleven of the sixteen mothers we interviewed were divorced, separated, or widowed and claimed they had little financial support from the child's father. This was not an artefact of mental illness. Female-headed households have steadily risen in Ghana and now form over a third of total households (Ghana Statistical Service 2012). Given the fluidity of marriage status in Ghana, divorce or separation is common, and even women who remain

married are not necessarily co-resident with the husband. National and international migration is high in Brong Ahafo as throughout Ghana (World Bank 2016) and exerts a significant impact on family life. Many men from poorer households in Kintampo try the route north across the Sahara to Libya[8], others migrate to the larger cities to the south in search of wider opportunities. Although a high proportion of professional women such as nurses migrate, poorer women with little education are often much less mobile. Despite longstanding participation in trade and the informal economy, women remain the primary caretakers of children and the domestic space.

Rising inequality and increases in the cost of living place intensify the strains on poorer households. The father has long been expected to play a crucial role as provider for his children, even within traditionally matrilineal societies in Ghana (Boni 2001). Taking responsibility for others is a critical marker of social maturation (Gyekye 1996) - a grown man may still be referred to as a 'boy' if he has failed to acquire responsibilities including providing for children, and building a house (Miescher 2005). However meeting such obligations has become increasingly difficult as employment opportunities remain limited, particularly for men from poorer households and with less education. For women, separation, migration or divorce, further threaten the reliability of a father's support. A husband or other relative abroad is perceived as a boon, despite the physical separation, as there is an ever-growing reliance on remittances[9] and family donations to meet household expenses, including health costs, and provide capital to build a house or establish a business (Kabki, Mazzucato, and Appiah 2004). However the husband may fail in his duty, or take another wife overseas and remittances dry up. As with Moses' mother, 'disappointment' in expectations of support from the husband was a common theme. In the event of illness such disappointment could become particularly acute, since fathers are expected to pay the

medical expenses of their children. Although a woman is expected to earn her own income and thereby gain some measure of financial independence (Clark 1994:107), as with Moses' mother, the responsibilities of care could result in the neglect of trading or farming enterprises. Women could thereby become more reliant on men as providers.

The moral imperative of care

Whilst Moses' father's failure to pay his son's medical expenses could be construed as a failure of his paternal responsibility, the moral stigma attached to madness, in particular that considered to be 'self-inflicted' through the use of cannabis or 'medicines', may have relieved him of some approbation. Furthermore, where men were living elsewhere their physical absence enabled them to escape the consequences of such judgement. However the moral force of family obligation could trump the stigma of mental illness, particularly in the context of a town like Kintampo where anonymity is rare, as Moses' mother experienced when she attempted to deny her son. Since, as Livingston notes in Botswana, 'cure-seeking is a moral imperative' (2005:47), families could be the target of accusations of neglect for failing to provide adequate care or treatment. One informant explained:

> When the person is roaming about and they know the actual family the person is coming from, when you are passing by they will be looking at you and be saying all sorts of things [….] people will be talking against you, maybe you are not trying your best.

Though the finger might point at 'the bad family', the burden of responsibility and the shame of public neglect appeared to fall most heavily on mothers. The idealised position of women in Ghanaian society as the bearer and nurturer of children appeared to make them less able to

escape sanction if they were perceived to have neglected a child. Whilst men's status is largely acquired beyond the domestic sphere, for women her status is gained primarily through her role as wife and mother and to be childless is considered a tragedy. The vivid imaginary of the perversion of maternal nurture in the figure of the witch who 'eats' rather than feeds her child paradoxically highlights the symbolic potency of the mother in Ghana. The mother has power both to destroy her child through bewitchment or curse, and to restore her child's social personhood through nurture and care. Several informants accused the mother of causing their madness through witchcraft. Yakub's mother described his accusations and murderous threats: "When he sees me, he is angry with me […] he says if I joke, he will stab me with a knife. When he sees me, he says I am a witch." Yakub ceased all contact with his mother, refusing to eat in her house, adding to her loneliness and isolation.

As the visible embodiment of such idealisation and demonization, mothers had most to fear from public judgement in Kintampo and the surrounding villages, where life is lived under the eye of family, neighbours, and friends, as well as potential enemies. Kwabena's mother, who was also at the shrine, described how people had accused her of "neglecting" her child by not seeking treatment. However she argued: "It isn't like I have neglected him. It is a money issue. I don't have money." Since no help was forthcoming from her family, she had searched for a large loan so that she could bring Kwabena to the shrine. After using this to pay for a taxi and the initial payment at the shrine, she was forced to find a further loan to complete his treatment. A woman such as this who is believed to neglect her child might legitimately fear being perceived as selfishly witchlike if not a witch indeed.

'Struggling in vain'? The search for a cure

Persistence with care was not simply a consequence of the moral imperative. Affective ties were strong, and families often went to extraordinary lengths to prevent the loss of a child to madness, countering the narrative of 'abandonment' which has often been portrayed as the corollary of stigma, state neglect and poverty (Biehl 2005). It is common for mental health workers to decry such stigma and condemn the families who banish their relatives to the street or the asylum. Whilst this undoubtedly occurs, many families in Kintampo expressed fears that their son or daughter might wander from home and become one of the dishevelled and outcast 'mad' vagrants who can be seen in Ghana's cities, and form for many Ghanaians the stereotype of madness and social extrusion. This was the case even, as with Moses, where the person engaged in behaviour such as smoking cannabis which was widely considered to be morally reprehensible and a contributing factor in mental illness. The use of chains and shackles to prevent the person from wandering from the family compound or a healing church or shrine could from this perspective be viewed less as human rights abuse, than a manifestation of care in profoundly desperate circumstances (Read, Adiibokah, and Nyame 2009). One father told me of travelling to Tamale, a city at three hours distance from Kintampo, to search for his young daughter who had wandered from home. A graduate from Ghana's second university who we first met in Kintampo in 2006 had been admitted to the psychiatric hospital several times, as well receiving treatment at the shrine and a local church. When we visted the family in 2016 his mother told us how he had become homeless on the streets of Accra and she arranged for friends to search for him. After one month they finally located him and took him for treatment at an expensive fee-paying drug rehabilitation unit which has been set up at Pantang hospital, just outside Accra. At the time of fieldwork the mother was seeking treatment from community mental health services but her son adamantly refused.

However the popular perception of madness as incurable, reinforced by frequent relapses, meant that several carers reported that relatives perceived spending money on treatment as throwing money to waste. In these cases it was often the mother as the person with both the strongest emotional attachment and the highest moral obligation who is the last to give up. Moses' mother's rhetorical question 'Can I ignore him?' can be read as reflecting these dual moral and affective imperatives. The reluctance to give up, to let a child "spoil," was demonstrated in extraordinarily prolonged efforts to seek treatment often at considerable expense, as Moses' mother's story illustrates. Though he had rejected her as a witch, Yakub's mother described herself as willing to go to any expense to cure him: "Wherever I can go for my child to get healed, I will go [….] if ten million [old cedi] can stop the sickness, and I even have ten million in my hand I will give [it] to you so that my child could be well." Similarly with Yaw, another man who, by the time we found him at the shrine, had been ill for six years. Despite the long duration of his illness, his mother had persisted with his treatment against family advice. His brother, who was living in Europe, paid the *aseda* and also met the expenses of Yaw and his sister during their year at the shrine. However Yaw's sister complained that their *wɔfa*, who was also overseas, had declined to spend money on Yaw's treatment, seeing his case as beyond help. Members of the matrilineage, she said, had told her she was "struggling in vain." "When I go back they don't even ask how he is. They think he is spoiled so we are struggling in vain. When I go there, some even tell me to leave him." This resulted in a "spoiling" of relations between Yaw's mother and her brother and the loss of his support. Yaw's sister speculated: "Perhaps they wanted us to leave him because it was too late. But my mother said she couldn't leave him to go to waste like that."

Conclusion: Families and community care in Africa

The trope of the African family in mental health planning in the African continent has been remarkably enduring from the colonial administrators who saw an alternative to institutional expansion and the horrors of the asylum, to the postcolonial psychiatrists concerned to establish an 'African psychiatry' which drew on the perceived strengths of the African family (Heaton 2013). Following the WHO schizophrenia studies, speculations on the value of the extended family presumed that with the right kind of research, including anthropological, one might be able to open the 'black box' of culture and reveal the particular aspects of family life which supported recovery (Hopper 2004). Since the 1970s and Alma Ata, WHO has advocated the integration of mental health into primary care and community-based treatment, including establishing collaborations with 'community agencies' and families (WHO/WONCA 2008, Jacob 2017, Sartorius and Harding 1983). Whilst this impetus may have its roots in an ideological move towards 'deinstitutionalisation', there is also an economic logic to reduce state investment in inpatient facilities. Implementation of this approach in low-income countries has been limited, not least due to the weakness of primary care in many settings (Hanlon, Wondimagegn, and Alem 2010), but the policy has been reinvigorated in the last decade through the advocacy and initiatives of 'global mental health' (Lancet Global Mental Health Group, 2007). The provision of community-based care aims to reduce the use of inpatient care in remote psychiatric institutions and bring care closer to the 'doorstep' of the family home, as Ghana's community mental health workers put it.

The expansion of community mental health care in Ghana meant that by 2016 fifteen of the cases were receiving treatment (mainly in the form of pharmaceuticals) from community mental health workers[10]. However the success of this policy is jeopardised by the increasing fragility and fragmentation of publically-funded health and social care systems (Jacob 2017) . Community-based care for mental illness, as with other chronic conditions, can place greater

responsibility on families, not just for assisting with care as nurture – providing food, shelter and companionship – but also with care as treatment – the supervision of drug regimes, the monitoring of symptoms, and other aspects of what Mattingly and colleagues have called 'chronic homework' (Mattingly, Grøn, and Meinert). In the case of severe mental illness families are often called upon to play a critical role in ensuring adherence to pharmaceutical regimens since patients may refuse medication, or be unable to manage medication themselves. In Ghana, it is nearly always a family member not the patient who takes custody of medication supplies following consultations with health professionals. This family member, very often the mother, oversees the daily administration of medication, sometimes hiding tablets in the patient's food, and is responsible for seeking follow-up and refills. Medication is valued by family carers for calming troublesome behaviours, particularly aggression, restlessness and 'talking too much' (Read 2012). However despite these improvements many of those in this study were unable to return to full productivity, and continued to present disturbing behaviours which impacted on family life such as urinating in inappropriate places, 'roaming around', or sleeping 'too much'.

In settings such as Ghana where health services are increasingly over-stretched and there is minimal welfare provision, the demands on the family are highest. There are risks that community-based models of care may deepen inequalities through transferring a greater responsibility for care to the poorest families who struggle to meet their basic needs (den Hertog & Gilmoor, 2016). Such inequalities are already evident as both inpatient and community mental health services have begun to impose charges, thus excluding those who cannot pay for them. Rather than mental illness as an exceptional 'crisis' erupting into an otherwise stable social order, for the poorest and most marginalised the everyday management of family life can be in itself a situation of endemic crisis (Vigh 2008). Yet, as

Das (2015) notes, it is only within such everyday life and relationships that care can be offered. In such precarious contexts, the advent of mental illness can tip a family further into debt and expose and deepen the fissures within family relationships. The family can then be less of a resource for care than one in need of resources to sustain care.

Advocates of community-based care propose that such household poverty can be offset, at least to some extent, by the wider social network glossed as 'the community'. However the imaginary of African communities is vulnerable to the same nostalgia that haunts the African family. The precise meaning of 'community' is often taken to be self-evident in global health policy, but in practice may comprise diverse 'publics' from religious groups, to traditional authorities, NGOs and 'civil society' organisations (Kelly, MacGregor, and Montgomery 2016). Such groups are dynamic and exposed to the same social and economic pressures as African families. Yet they are increasingly called upon to complement under-funded and over-stretched mental health services, particularly to meet social or psychological needs. In Ghana the chronic lack of funding for mental health services, and absence of a dedicated mental health budget within primary care which is responsible for providing the logistics for community mental health workers, mean that supplies of pharmaceuticals, transport and fuel to carry out even the most basic treatment are unavailable or unreliable. Churches, NGOs and corporate donors intervene to plug the gaps, for example with one-off donations of medicines, sanitary supplies, and motorbikes, but without a secure health infrastructure it is hard to develop more sustainable interventions to support families, particularly in more remote communities.

Family care can be a precious and valued resource, evident in the enduring commitment of many of the informants in this study, whose care was essential to prevent homelessness and

social isolation. However the viability of the family as a source of care is vulnerable to the impacts of increasing mobility, changing patterns of employment, and reductions in public services, whose effects will be felt most in the poorest households. In this case it is not so much traditions of family care which are under threat from globalising processes of social, political and economic change, indeed, as this study shows, their moral force remains, but the ability of families to meet them.

Endnotes

[1] Asylums were instituted in Britain's African colonies at the end of the 19th century but remained few in number. Accra Psychiatric Hospital opened in 1906 and functioned largely for the custody of highly disturbed or violent patients. Another two psychiatric hospitals were constructed after independence, also in the south of Ghana.

[2] Care within Ghana's public psychiatric hospitals is officially free of charge but frequent funding crises often mean that charges are introduced to make up the funding shortfall. There are a significant portion of patients in the hospitals who have no contact with family, and so are dependent on whatever resources the hospital provides.

[3] Shrines and prayers camps are popular resources for treatment of mental illness in Ghana. People with mental illness often stay at such places for several weeks, months or even years. Prayer camps are run by Pentecostal pastors and offer healing predominantly through prayer, fasting and deliverance from evil spirits. Shrines are devoted to *abosom*, the 'small gods' who possess the incumbent *ɔkɔmfo*, referred to in English as a 'fetish priest' or 'traditional healer'. The *ɔkɔmfo* usually offers treatment with herbal medicines as well as performing rituals, including animal sacrifice, to address the presumed cause of the illness, such as witchcraft, curses or misdemeanours on the part of the patient. The healing landscape in Ghana is complex and dynamic and there is much intersection and exchange between the forms of healing from diverse traditions, including biomedicine. See for example Hampshire and Owusu (2013). For more on family experiences of using such healers for mental illness see Read (2016).

[4] Interviews and fieldwork were conducted with a research assistant fluent in Twi and English. The majority of interviews with patients, family members and healers were in Twi. Interviews with health workers and students were in English. Wherever possible we interviewed the person with mental illness, however some were too unwell to provide consent or to participate in the interview, in which case we interviewed a mother, father, or sibling (see Table 1). In several of the interviews the carer and the person with mental illness were interviewed together. Interviews were digitally recorded and transcribed verbatim. Twi interviews were transcribed into Twi and translated into English. Ethical approval for the study was granted by University College London and Kintampo Health Research Centre in 2007-8 and Ghana Health Service and Kwame Nkrumah University of Science and Technology in 2015-16.

[5] All names are pseudonyms.

[6] The cost of traditional or faith healing can be considerable often amounting to the equivalent of several hundred US dollars (see Read 2016). Families bringing relatives to the shrine are instructed as to the specific items to be purchased and cash payments to be made which vary depending on the treatment. These typically include animals such as sheep and chickens for sacrifice, alcohol for libations, and goods such as cloth. These are used in the initial process of divination to determine the diagnosis and treatment, a payment known as *ntoaseɛ*, and again at the end. The *aseda* (meaning thanks) should strictly speaking only be made if healing is deemed to be successful. However in most cases I met the family were obliged to pay the *aseda* before leaving even if the person was not considered completely healed. At the churches payment is usually framed as 'offerings' in thanks for treatment received.

[7] Kintampo is in the centre of Ghana and home to a mix of ethnic groups including Akan and various groups from Northern Ghana. The Akan, the majority ethnic group in Ghana, are matrilineal, but groups from the North of Ghana are patrilineal. The case studies came from a mix of Akan and northern groups.

[8] This route has been somewhat disrupted since the fall of Gadhafi in Libya. Nonetheless young men continue to take this route, despite risks of imprisonment, injury or death. However rather than remain in Libya as before to work in construction or as domestic workers, it appears increasing numbers attempt the 'back door' to Europe via the Mediterranean.

[9] Ghana is among the highest recipients of remittances in the world, reflective of high rates of external migration to OECD countries, particularly among those with tertiary education (World Bank 2016).

[10] Four of these cases were not receiving treatment from psychiatric services at the time they were seen by the researchers. The researchers informed local mental health services who visited the families and began treatment.

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